#### Rackground Information

Ass∈	essment Start Date	Backgroun  Honth Day Year	u into	rmation Provider-Assessor	#
		oordinating Assessmenton			
	-				Priorie Number
1.	APPLICANT NAME	First: (MI) Last:	13.	OR POTENTIAL PAYMENT SOURCE (Code a	Not eligible     Eligible     Eligibility pending (application filed)     Eligibility anticipated (application not yet filed)     Unknown
2.	ADDRESS	StreetCity/TownCntyState ZipPhone ()	-	response in each box.)	a. Community MaineCare (Routine home health, PDN) a g. h. VA h. h. C. HCB - Phys. Dis. d. NF MaineCare d. NF MaineCare a. Community MaineCare a. Community MaineCare a. C. HCB - Phys. Dis. d. NF MaineCare a. C. L. J. Discourse a. C. L. J. Disc
	SECURITY NO.  MAINECARE NO.  (if applicable)		-		e. Medicare Part A  f. Medicare Part B  f
5.	MEDICARE NO.		14.	TIME OF	Hospital
6A.	ASSESSMENT TRIGGER	Service Need 3. Significant Medical Change     Reassessment due 4. Financial Change     InantemCareAdvisory 17. 30-dayCommunityMaineCareNF		ASSESSMENT & USUAL RESIDENCE	Congregate housing     A Residential Care Facility     Other
6B.	PROGRAM ASSESSMENT REQUESTED	2 AdultDayCareProgram 18. AdvisorytoMainsCareUpdate 19. Adv. MedicaretoPrivatePayNF 20. ContinuingStayReview			A. Location at time of assessment  B. Usual place of residence
	(Choose only one.)	5 Consumer Directed PCA 6 Home Based Care 7 Hys. Dis. HB 8 Elderly HB 9 Adultsw/Disskillity HB 10. HDN-Level I., III 11. Adult Family Care Home 12. Level V-Extended HD 13. NFASSESSMENT 29. Consumer Directed HC 14. 20-day water Owner and the state of th	15.	USUAL LIVING ARRANGEMENT	Lives with: (Check all that apply.)  a. Alone b. With spouse c. With children d. With other residents d. With other 1 column 1 column 2 column 2 column 2 column 3 column 2 column 3 co
7.	GENDER	1. Male 2. Female	16	NO. IN HOUSEHOLD (Incl. applicant)	Other than in institution/residential care facilities
9.	RACE/ ETHNICITY (Optional) BIRTH DATE	1. American Indian/Alaskan 4. Hispanic 2. Asian/Pacific 5. White 3. Black 6. Other  Month Day Year	17.		(Check all that apply.)  a. Legal guardian a d. Family member responsible oversight e. Applicant responsible e.
10A.	MARITAL STATUS	1. Never married 2. Widowed 5. Divorced 2. Married 4. Separated 1. U.S. Citizen 2. Legal alien 3. Other		documentation)	c. Durable power attorney/ health care proxy g. Unknown g.
10B 11.	PRIMARY LANGUAGE	0. English       2. Spanish         1. French       3. Other	18.	ADVANCED DIRECTIVES	(Check all that apply.)
12.	CURRENT INCOME SOURCE FOR APPLICANT & HOUSEHOLD	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		(For only those items with supporting documentation)	a. Living will b. Do not resuscitate c. Do not hospitalize d. Organ donation e. Autopsy request e. Autopsy request e. Do not hospitalize d. Organ donation e. Autopsy request e. Autopsy request e. Do not hospitalize c. Do not hospitalize d. Organ donation e. Autopsy request e. Autopsy request e. Autopsy request e. Do not resuscitate b. Do not resuscitate c. Do not hospitalize c. Do not hospitalize c. Do not hospitalize d. Organ donation e. Autopsy request e. Autop
10	CONTACTS				
A.	Name			Name	
		Legal Guardian Yes No	_ ,	Relationship	Legal Guardian Yes No
	REFERRING PHYSI	CIAN		NTINUING PHYSICIA	N
Te	elephone		Tele	ephone	
Н	omebound 0 - N	No. 1 - Yes			

SECTION A. PROFESSIONAL NURSING SERVICES  Use the following codes for section A.1 A.10 (severy block should be coded with a response) of a registered professional nurse.  10 UNCONTROLLED  SCRUIR DEPOSITION OF SECTION A. PROFESSIONAL NURSING SERVICES  Use the following codes for section A.1 A.10 (severy block should be coded with a response) of a registered professional nurse.  10 Condition (rectament not present in the last 7 days.  10 Condition (rectament not present in the last 7 days.  11 -12 days week  12 -3 days week  13 -4 days week  14 -7 days week  15 -6 days week  16 -7 days week  17 days week  18 -8 days week  19 defection that is manufactorized injection of the security of the secur	Agei	ncy Name:			Aı	oplicant Name <u>:</u>		
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in V FEEDING Condition (excluding a daily insulin for a person whose diabetes is under control):    Total Condition   Conditio	1	INIECTIONS/	for an unctable				Total # of days of therapy per week:	
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control):			dully illisalili for a	d	12	THERAPY		
FEEDING TUBE  Feeding tube for a new/ recent (within 30 days) or an installate condition.  TRACH CARE  3. SUCTIONING/ TRACH CARE  1. Trachesostomy care for a new/ recent (within 30 days) or an installate condition or a month. Specify condition and code for applicant's need.  Please specify  13. ASSESSMENT/ DRESSINGS  Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or sterile dressings and which requires the skills of an RN:  a. Stage 3 or 4 decubitus ulcers b. Open surgical site c. 2-dor 3rd degree burns c. 2-dors 3rd decubitus ulcers b. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and turnor erosions) tube sites and turnor erosions) c. Other  5. OXYGEN  Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional unrising assessment, observation and management required for installe medical conditions. Observation of medical degree burns c. 2-dors 3rd degree burns c. 4. TREATMENTS Code for number of days care would be performed by or under the supervision of a registered nurse.  1. TREATMENTS Code for number of days care would be performed by or under the supervision of a registered n			e. Intravenous feeding	u I				
2. FEEDING TUBE  recent (within 30 days) or an unstable condition in Insertion addte:  c. jejunostomy tube  a. Nasopharyngeal suctioning a b. Tracheostomy care for a new/recent (within 30 days) or an unstable condition in Sacrify condition and code for applicant sneed.  Please specify  Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed in Sacrify and which requires the skills of an Riv.  a. Stage 3 or 4 decubitus ulcers and which requires the skills of an Riv.  b. Open surgical site c. 2nd or 3rd degree burns d. Stassis ucler g. e. Open lesions other than stass/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions) f. Other  5. OXYGEN  Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.  Start date.  6. ASSESSMENT/ MANACEMENT  Professional nursing assessment, observation and management requires the skills of an Riv.  Frofessional nursing assessment observation for a new/recent (within 30 days) condition.  Professional nursing assessment, observation of a new/recent (within 30 days) condition.  Professional nursing assessment, observation of a urethral or sustable medical conditions.  Discrardate.  6. ASSESSMENT/ MANACEMENT  Treatment and/or applicant's need.  1. TREATMENTS Code for number of days care would be performed by or where the supervision of a registered murse.  1. TREATMENTS CHONIC CONDITIONS  2. Treatments of a fact season except shours.  3. Once a month  Professional nursing assessment, observation for a new/recent within 30 days) condition.  5. OXYGEN  Administration of treatments, procedures, or dressing changes which involve prescription medications via trube  a. Lineary care-chronic stable c. Urinary catheter change d. Urinary catheter change d. Urinary catheter injection and maintenance of aurethral or supervision of a urethral or supervision of a surethral or supervision of a pr			(Parenteral of IV	е			0 - NO 1 - YES	
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TRACH CARE    D. Tracheostomy care for a new/recent (within 30 days) or an unstable condition			c. Jejunostomy tube	С				
4. TREATMENT/ DRESSINGS  Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed irrigation, application of medications, or strelle dressings and which requires the skills of an RN:  a. Stage 3 or 4 decubitus ulcers b. Doen surgical site c. 2nd or 3rd degree burns d. Stasis ulcer e. Open lesions other than stasis/pressure ulcers or cuts (including bur not limited to fistulas, tube sites and tumor erosions) f. Other  5. OXYGEN  Administration of oxygen on a regular and continuing basis when recipient's condition.  Start date:  Treatment and/or application of dressings for one of the following conditions according to physician or derays/week 2. 3 or more days/week 3. 3 or more days/week 3. 1 TREATMENTS. CAGE for number of days care would be performed by or medications, one are guitar and continuing basis when recipient's condition of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.  a. Medications via tube b. Tracheostomy care-chronic stable c. Urinary catheter irrigation d. Start date.  Professional nursing assessment, observation and one management required for unstable medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need.  Please specify  7. CATHETER  Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  Professional nursing assessment of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  2. TREATMENTS.  Code for number of days verolessional nursing is required.  1. 1 - 2 days/week 2. 3 or more days/week 3. Once a month  2. TREATMENTS. Code for numb	3.			а			0 NO 1 VEC	
4. TREATMENT DRESSINGS  Treatment and/or application of dressings for one of the following conditions for which the physician has prescribed frigation, application of medications, or sterile dressings and which requires the skills of an RN:  a. Stage 3 or 4 decubitus ulcers b. Open surgical site c. 2nd or 3rd degree burns d. Stasis ulcer or cuts (including but not limited to fistulas, tube sites and tumor erosions) f. Other  5. OXYGEN  Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/ recent (within 30 days) condition.  Start date:  6. ASSESSMENT/ MANAGEMENT  MANAGEMENT  7. CATHETER  Insertion and maintenance of a urrethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  8. COMATOSE  Professional a ursing assessment, observation and maintenance of a urrethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  8. COMATOSE  Professional a ursing assessment, observation or a new/ recent (within 30 days) condition.  7. CATHETER  Insertion and maintenance of a urrethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  8. COMATOSE  Professional care is needed to manage a commatose condition.  9. VENTILATOR/ RESPIRATOR  Care is needed to manage ventilator/ respirator equipment.			(within 30 days) or an unstable condition	b			0 - NO 1 - YES	
6. ASSESSMENT/ MANAGEMENT  Professional nursing assessment, observation and management required for <u>unstable</u> medical conditions. Observation must be needed at least once every 8 hours. Specify condition and code for applicant's need.  Please specify  7. CATHETER  Insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition.  8. COMATOSE  Professional care is needed to manage a comatose condition.  Professional nursing assessment, observation and maintenance of a urethral or suprapuble catheter as an adjunct to the active treatment of a disease or medical condition.  2. TREATMENTS/ PROCEDURES  Not required 1. 1-2 days/week 2. 3 or more days/week 3. Once a month  a. Chemotherapy b. Radiation Therapy b. Radiation Therapy c. Hemodialysis c.		DRESSINGS	following conditions for which the physician has pre irrigation, application of medications, or sterile dres and which requires the skills of an RN:  a. Stage 3 or 4 decubitus ulcers b. Open surgical site c. 2nd or 3rd degree burns d. Stasis ulcer e. Open lesions other than stasis/pressure ulcers or cuts (including but not limited to fistulas, tube sites and tumor erosions) f. Other  Administration of oxygen on a regular and continuing basis when recipient's condition warrants professional observation for a new/recent (within 30 days) condition.	a b c d	1.	CHRONIC	or under the supervision of a registered nurse.  0. Not required 1. 1-2 days/week 2. 3 or more days/week 3. Once a month  Professional nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders.  a. Medications via tube b. Tracheostomy care-chronic stable c. Urinary catheter change d. Urinary catheter irrigation e. Veni puncture by RN	a. b. c. d.
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9. VENTILATOR/ Care is needed to manage ventilator/ RESPIRATOR respirator equipment.							· · · ·	
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							d. Peritoneal Dialysis	d.

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	If 4A = 1 (YES), proceedings of the contract o																CUEING Activity											eek				ن ا	FOR	SUPPORT
	of the MaineCare	Bene	fits	Man	ual, tl	hen	go t	to pa	age 2							0.	Activity	uiu ii		ui uu							73.					Ū	H H	SUP
	Section C.4B of th	e Su	оріє	men	tai Sc	reer	ning	100	4.							a.	BED		perso												turi	ns		
5.	Is professional nu	rsinc	1 25	222	ment	ohs	erva	ation	and	l ma	anagg	ment			_	MC	DBILITY	side	to sic	ie, an	ıa p	305	ILIC	)ns	S DC	ouy	wnı	ie ii	1 be	u 				
.	required once a m				age a	ıll th	ie ab			nitiv	ve pa					b. TR	ANSFER		perso													_		
					0	-NO	)		—	1 -	- YES		L						rom ba				, ,	, ta	iiui	ng	pus	itio	I (L)	\CL	.001	-		
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					PRO													roo	m and	othe	er a	rea	ıs c	on	san							air,		
1.	Column A Codes: Co 0. Behavior not ex						if bei	navi	or <b>in</b>	ias	it / a	ays						self	suffic	iency	or	ice	in (	cha	air									
	<ol> <li>Behavior of this</li> <li>Behavior of this</li> </ol>											ilv	_A_	B_		d. DF	RESSING		perso															
	3. Behavior of this						ays,	but	1633	tiia	ııı ua	ııy	<u> </u>	≽					et clotl				_									515	_	
	Column B Codes: A					avioi	ral s	symp	tom	s			FREQUENCY	ALTERABILITY		e. E.	ATING	How	perso	on ea	ts a	and	dr	in	KS (	reg	jard	iess	of s	skil —	I)			
	Not present or 6     Behavior not eas												REO	ĹŢĖ		f.TOI	LET USE		perso															
	Denavior not ea.	J.1. y C		-u										1					pan, u 1ges p													s		
	a. WANDERING (mo		with	no i	ation	al pı	urpos	se, s	eemi	ingl	y obl	ivious						clot	nes															
	b. VERBALLY ABUSI		thei	s we	re thr	reate	ened,	, scr	eame	ed a	at, cu	rsed					RSONAL YGIENE		perso															
	at)	ICIV/E	(a+h		ا میمید	ن داد	ماء	مامد		-6	رمم لم	بالمين				П	TGIENE		bing heup, v													m		
	c. PHYSICALLY ABU abused)	SIVE	(011	iers v	vere r	iit, S	MOVE	eu, s	Cracc	inec	ı, sex	cually							LUDE								unus	, aı	та р		icui	"		
	d. SOCIALLY INAPPI sounds, noisy, se															3. W	ALKING	a. F	low pe	rson	Wa	alks	fo	r e	exe	rcis	e or	ıly						
	disrobing in pub	olic, s	mea	red/	threw	/ foo	d/fe											b. F	low pe	rson	Wa	alks	ar	ou	ınd	ow	n ro	om						
	rummaged throu	-			-	-		/iniec	tions	s. A	DL							c. F	low pe	rson	Wa	ılks	wi	ith	in h	ıor	ne							
	assistance or ear		-	5			,	,		-,								d. F	low pe	rson	Wa	alks	οι	ıts	ide									
2A.	Is professional n	ursi	ng i	asse	 ssme	ent.	obs	erva	atior	ı ar	 1d		1	1		4. BA	ATHING	Hov	v pers	on ta	ake	es f	ull	-b	odv		ath/	'shc	wei	r, s	pon	ige ba	ıth.	
	management rec	quire	d a	t lea	ist 3 (							the	_					and	trans	fers	in,	ou/	t o	of t	ub,	/sł	owe	er (	EXC	LUI	ĎE v	washir		f
	behavior probler	ns—	ıter	ns a	-d?		0	- NO	,	1	- YES								k and forma													elf nance	cod	es
	If 2A = 1 (YES), prod	دممط	to ?	lf ɔ	Δ – Λ	(NIC							L						ear b									, -(	, .	1			-501	-
	behavioral impairm	ent t	hres	hold	as de	efine	ed in	Cha	pter	II, S	Sectio	n 67 d	of						ndepe uperv														1	2
	the MaineCare Bene Section D.2B of the								4 and	oo t	mple	te						2. F	hysica	ıl heli	p li	mit	ed	to	tra	ınst	er o	nly					NCE	
3.							-		tion	ıar	ıd m	anade	<u>-</u>						hysica otal d					of	bat	hir	ig ac	ctivi	ty				ORM,	ORT
	ment required or												_					5. (	CUEIN	Ξ—Cι	uei	ng	sup								we	ek   ដូ	PERFORMANCE	SUPPORT

0 -NO

1 - YES

CLINI	Page 2A of 5
Agency Name:	Applicant Name:  Social Security #
SECTION C.4B. COGNITION	SECTION D.2B. BEHAVIOR
Enter the code that most accurately describes the person's cognition for the last 7 days.	Enter the code that most accurately describes the person's behavior for the last 7 days.  1. SLEEP PATTERNS:
1. MEMORY FOR EVENTS:  0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.  1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.  2 Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.  3 Cannot recall entire events or name of spouse or other living partner even with prompting.	O Unchanged from "normal" for the consumer.  Sleeps noticeably more or less than "normal."  Restless, nightmares, disturbed sleep, increased awakenings.  Up wandering for all or most of the night, inability to sleep.  WANDERING:  Does not wander.  Does not wander. Is chair bound or bed bound.  Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.  Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of
MEMORY AND USE OF INFORMATION:     Does not have difficulty remembering and using information. Does not require directions or	getting lost and is not combative about returning.  4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the
reminding from others.  1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.  3 Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions.  4 Cannot remember or use information. Requires continual verbal reminding.	use of psychotropic drugs for management and safety.  3. BEHAVIORAL DEMANDS ON OTHERS:  0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.  1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.  3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or
3. GLOBAL CONFUSION:  0 Appropriately responsive to environment.  1 Nocturnal confusion on awakening.  2 Periodic confusion during daytime.  3 Nearly always confused.	existing facility staffing.  4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.  4. DANGER TO SELF AND OTHERS:
4. SPATIAL ORIENTATION:  0 Oriented, able to find and keep his/her bearings.  1 Spatial confusion when driving or riding in local community.  2 Gets lost when walking neighborhood.  3 Gets lost in own home or present environment.	1 Is not disruptive or aggressive, and is not dangerous. 1 Is not capable of harming self or others because of mobility 'limitations (is bed bound or chair bound). 2 Is sometimes (1 to 3 times in the last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment. 3 Is frequently (4 or more times during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious;
5. VERBAL COMMUNICATION:  0 Speaks normally.  1 Minor difficulty with speech or word-finding difficulties.  2 Able to carry out only simple conversations.	<ul> <li>and professional judgment is required to determine when to administer prescribed medication.</li> <li>Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.</li> </ul>
3 Unable to speak coherently or make needs known.  C.4B TOTAL COGNITIVE SCORE	5. AWARENESS OF NEEDS/JUDGMENT:  0 Understands those needs that must be met to maintain self care.  1 Sometimes (1 to 3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.  2 Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.  3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.
	D.2B TOTAL BEHAVIOR SCORE
Return to Section C5 on page 2.	Return to Section D3 on page 2.

#### **CLINICAL DETAIL**

	C	LINICAL D	ETAIL							Pag	ge 3 of 5
Agency Name:			Applicant Na	me <u>:</u>							
rovider-Assessor #	-		Social Securit	ty#		-	-			]	
			Assessment [	Date:		7111		뺍	П	_	
	SECT	ION F. MEDICA	TIONS LIST								
List all medications given during the last 7 days					ly as p	art of	the pe	son's	treatm	ent regi	men.
1. List the medication name and the dosage	anda from tha	fallawing list.									
2. RA (Route of Administration). Use the appropriate  1 = by mouth (PO)  2 = sublingual (SL)  4 = intravenous	lar (IM)	following list: 5 = subcutane 6 = rectally	ous (SubQ)			opical nhalati	on			nteral tu other	be
3. FREQ (Frequency): Use the appropriate frequency	code to show th	ne number of times	. ,			_					
PR = (PRN) as necessary 1H = (qh) every hour 2H = (q2h) every two hours 3H = (q3h) every three hours 4H = (q4h) every four hours 4H = (q4h) every four hours 4H = (q4h) every four hours 6H = (q6h) every eigh 1D = (qd or hs) once of 2D = (BID) two times of (includes every)	t hours 4D daily 5D daily 1W	= (TID) three times d = (QID) four times d = five times a day = (QWeek) once ever = twice every week	laily C 4 ry week 5	BW = three to the second secon	other da mes eve nes eve	ay ery week ry week	( 2	nonth	ice every	once ever	У
<ol> <li>PRN-n (prn — number of doses): If the frequency use this column for scheduled medications.</li> </ol>	code is "PR", rec	ord the number of	times during t	the past 7	days th	at each	PRN m	edicatio	on was 🤉	jiven. Do	o not
5. DRUG CODE: Enter the National Drug Code (NDC) the manual Appendix E. If using this Appendix, th left of the NDC code column). This should result in	e NDC should b	e entered left-justif	ied (the first d								
1.Medication Name and Dosage	2. RA	3. Freq	4. PRI	N-n			5. N	DC C	odes		
EXAMPLE: Coumadin 2.5 mg	1	1 W									
Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 5 1	1 D 1 D PR	2								
									ш_		
										1 1	
						<u> </u>	 			1 1	
							$\Box$			$\perp$	
									<u> </u>		
SECTION G. MEDICATION a. PREPARATION/ADMINISTRATION		1. DIAGNOSES: Chec		ECTION				curren	nt ADL st	atus cod	nitive
Did person prepare and administer his/her own		status, mood and inactive diagnoses	behavior status	s, medical t	reatmen	its, nurs	e monit	oring, o			
<ul><li>in the last 7 days?</li><li>0. Person prepared and administered ALL of his/her own m</li></ul>	nedications.	ENDOCRINE/MET		NEUROLO	GICAL			SENS	ORY Catara	. et e	
1. Person prepared and administered <u>SOME</u> of his/her own 2. Person prepared and administered <u>NONE</u> of his/her own		<b>NUTRITIONAL</b> a. Diabetes mel		q. Alzh	eimer's ( Isia	disease		∏kl	k. Diabet	tic retino	pathy
3. Person had no medications in the last 7 days.	medications.	b. Hyperthyroid c. Hypothyroidi		s. Cere	bral pals orovascul		ent (strok	$\vdash$	. Glauco ım. Macu	oma ılar deger	neration
<ol> <li>Person did not prepare but did self-administer all medica</li> <li>Facility prepares and administers medications.</li> </ol>	itions.	HEART/CIRCULA		u. Dem	entia oth eimer's o			ОТН		ies (specif	5.0
6. Person requires administration of medications due to se	vere	d. Arteriosclero	D)	v. Hem		nemipar	esis		o. Anemi	ia	(y)
and disabling mental illness.  b. COMPLIANCE		e. Cardiac dysrl		x. Para	olegia				p. Cance q. Renal		
Person's level of compliance with medications prescrib	ed	g. Deep vein th		z. Quad	nson's c Iriplegia				. Tuber s. HIV	culosis-TI	3
by a physician/psychiatrist in the last 7 days:  0. Person always compliant		i. Hypotension		aa. Seizu bb. Tran			tack (TI	ų) □tt			ion <i>(e.g.,</i> me, autism,
1. Person compliant some of the time (80% of time or mo	re often)	k. Other cardiov		□ cc. Trau		-	У		or oth	er organi	c condition al retarda-
<ul><li><u>or</u> compliant with some medications</li><li>2. Person rarely or never compliant</li></ul>		MUSCULOSKELETA	۱L	dd. Anxi	ety disor				tion o	r develop	mental
3. Person had no medications during last 7 days		I. Arthritis m. Hip fracture		ee. Depr		sive (bij	oolar)	u	u. Substa	lity (MR/E ance abus	se
<ol> <li>Person requires monitoring of medications due to seve and disabling mental illness.</li> </ol>	ere	n. Missing limb (		- 55	•	a		□v		ol or drug psychiatr	g) ic diagnosis
c. SELF-ADMINISTRATION Did person self-administer any of the following media	cations or	p. Pathological		hh. Asth	ma			_		paranoia, nality disc	
treatments in the last 7 days?	-4410113 01			∐ii. Empl					w. Explic		al prognosis
<ul><li>a. Insulin</li><li>b. Oxygen</li><li>d. Over-the-counter Meds</li></ul>		2. OTHER CURRI				DES .		^/		,. ,.50 <b>v</b>	
<b>c.</b> Nebulizers <b>g.</b> Other (specify)		b			Ţ.	ДĪ.	耳				
d. Nitropatch h. NONE OF ABOVE		С					ш				

Age	ncy Name:		A	Applicant Nar	ne <u>:</u>					
Prov	vider-Assesso	r #	S	ocial Security	v #					
			Α	Assessment D	Pate D					
		N I. COMMUNICATION/HEARING PATTERNS			TION L. CONTINENCE IN LAST 14 DAYS					
1.	HEARING	(With hearing appliance, if used)	1.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficien to soak through underpants) with appliances if used (e.g., pads or					
	(Choose only one.)	0. HEARS ADEQUATELY—normal talk, TV, phone		(Choose only	incontinence program employed) in <u>last 14 days</u>					
		1. MINIMAL DIFFICULTY when not in quiet setting		one.)	0. CONTINENT—Complete control					
		2. HEARS IN SPECIAL SITUATIONS ONLY—speaker			1. USUALLY CONTINENT — Incontinent episodes once a					
		has to adjust tonal quality and speak distinctly  3. HIGHLY IMPAIRED—absence of useful hearing			week or less					
$\vdash$					2. OCCASIONALLY INCONTINENT— 2 or more times a					
2.	COMMUNICA-	(Check all that apply during last 7 days.)			week but not daily					
	TION DEVICES/ TECHNIQUES	a. Hearing aid, present and used			3. FREQUENTLY INCONTINENT— tended to be incontinent daily, but some control present					
	1	b. Hearing aid, present and not used regularly			4. INCONTINENT—Bladder incontinent all (or almost all)					
		<ul> <li>c. Other receptive communication techniques used (e.g., lip reading)</li> </ul>			of the time					
		d. NONE OF ABOVE	2.	BOWEL	In last 14 days, control of bowel movement (with					
$\vdash$			2.	CONTINENCE	appliance or bowel continence programs if employed)					
3.	Making self Under-	(Expressing information content—however able)		(Choose only	0. CONTINENT—Complete control					
	STOOD	0. UNDERSTOOD		one.)	1. USUALLY CONTINENT — Bowel incontinent episodes					
		1. USUALLY UNDERSTOOD—difficulty finding words			less than weekly					
	(Choose only one.)	or finishing thoughts			2. OCCASIONALLY INCONTINENT— Bowel					
	one.)	2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests			incontinent episode once a week					
		3. RARELY/NEVER UNDERSTOOD			3. FREQUENTLY INCONTINENT— Bowel incontinent					
4.	ABILITY TO	(Understanding information content—however able)			episodes 2-3 times a week 4. INCONTINENT—Bowel incontinent all (or almost all)					
٦.	UNDER-				of the time					
	STAND OTHERS	UNDERSTANDS     USUALLY UNDERSTANDS—may miss some	3.	APPLIANCES/	a. External (condom) catheter					
	(Choose only	part/intent of message		PROGRAMS	b. Indwelling catheter					
	one.)	2. SOMETIMES UNDERSTANDS—responds		(Check all that apply.)	c. Pads/briefs used					
		adequately to simple, direct communication		Chart applying	d. Ostomy present					
		3. RARELY/NEVER UNDERSTANDS			e. Scheduled toileting/other program					
		SECTION J. VISION PATTERNS			f. NONE OF ABOVE					
1		(Ability to see in adequate light and with glasses if used)			SECTION M. BALANCE					
'-	VISION		1.	ACCIDENTS	_					
	(Choose only one.)	ADEQUATE—sees fine detail, including regular  point in province of the old.	'-	(Check all	30 days  d. Other fracture in last					
		print in newspapers/books  1. IMPAIRED—sees large print, but not regular print		that apply)	b. Fell in past 180 days					
		in newspapers/books			31-180 days e. NONE OF ABOVE					
		2. MODERATELY IMPAIRED—limited vision; not able	2.	DANGER	a. Has unsteady gait					
		to see newspaper headlines, but can identify objects		OF FALL	b. Has balance problems when standing					
		HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects		(Check all that apply)	c. Limits activities because person or family fearful					
		4. SEVERELY IMPAIRED—no vision or sees only light,		and dippryy	of person falling					
		colors, or shapes; eyes do not appear to follow objects			d. NONE OF ABOVE					
Ŀ		Character A NO 1 VEC			SECTION N. ORAL/DENTAL STATUS					
2.	VISUAL APPLIANCES	a. Glasses, contact lenses 0 - NO 1 - YES		0041						
	AFFLIANCES	b. Artificial eye 0 - NO 1 - YES	1.	ORAL STATUS	a. Has dentures or removable bridge  b. Some/all natural teeth lost—does not have or					
		SECTION K. NUTRITIONAL STATUS		AND	does not use dentures (or partial plates)					
F				DISEASE PREVENTION	c. Broken, loose, or carious teeth					
1.	WEIGHT	Record weight in pounds. Base weight on most recent measure in last 30 days; measure weight		(Check all	d. Inflamed gums (gingiva); swollen or bleeding					
1	(Optional if info is not	consistently in accord with standard practice		that apply)	gums; oral abscesses; ulcers or rashes					
1	available.)	(e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes)			e. NONE OF ABOVE					
H		- (/)			SECTION O. SKIN CONDITIONS					
2.	WEIGHT CHANGE	0. No weight change	1.	SKIN	Any troubling skin conditions or changes in the last 180 days?					
1	(Optional if	1. Unintended weight gain—5 % or more in last 30 days: or 10 % or more in last 180 days	1	PROBLEMS	a. Abrasions (scrapes) d. Rashes, itchiness, body					
1	info is not available.)	2. Unintended weight loss—5 % or more in last		(Check all	or cuts lice, scabies					
1	avallable.)	30 days; or 10 % or more in last 180 days		that apply)	b. Burns e. Open sores or lesions					
					c. Bruises f. NONE OF ABOVE					
3.	NUTRITIONAL PROBLEMS	a. Chewing or swallowing  f. Mechanically altered problem (or pureed) diet	_							
	OR	b. Complains about the g. Noncompliance with	2.	PRESSURE	Presence of an ulcer anywhere on the body? This would includ					
1	APPROACHES	taste of many foods diet		ULCERS	an area of persistent skin redness (Stage 1), partial loss of skin					
1	(Check all that	c. Regular or repetitive h. Food Allergies			layers (Stage 2), deep craters in the skin (Stage 3), and breaks in the skin exposing muscle or bone (Stage 4).					
1	apply)	complaints of hunger (specify)			0 - NO 1 - YES					
1		d. Leaves 25% or more of i. Restrictions food uneaten at most	3.	EOOT	7					
		moals (Specify)	٥.	FOOT PROBLEMS	a. Person or someone else inspects person's feet on a regular basis?					
		e. Therapeutic diet			0 - NO 1 - YES					
Щ					b. One or more foot problems or infections such as					
					corns, calluses, bunions, hammer toes, overlapping					
					toes, pain, structural problems, gangrene toe, foot fungus. onvchomycosis?					
				1	i iangua, onvenoniveosis!					

1 - YES

0 - NO

Agency Name:	Applicant Name:
Provider-Assessor #	Social Security #
	Assessment Date:
SECTION P. INSTRUMENTAL ACTIVITIES OF DAILY LIVING	SECTION Q. ENVIRONMENTAL ASSESSMENT  1. If person resides in a facility such as a NF, RCF, or hospital,
I. IADL SELF-PERFORMANCE CODES:     0. INDEPENDENT: (with/without assistive devices)—No help provided.	check here and proceed to Section R.
1. INDEPENDENT WITH DIFFICULTY: Person performed task, but did so	2. HOME a. Lighting (including adequacy of lighting, exposed a. Wiring)
with difficulty or took a great amount of time to do so.  2. ASSISTANCE/DONE WITH HELP: Person involved in activity but help	MENT b. Flooring and carpeting (e.g., holes in floor, electric
(including supervision, reminders, and/or physical "hands-on" help) was provided.	(Check any of the following the following b.
DEPENDENT/DONE BY OTHERS:     Full performance of the activity was done by others The person was not	that makes home c. Bathroom and toiletroom environment (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet) c.
involved at all each time the activity was performed.  8. Activity did not occur.	hazardous or d. Kitchen environment (e.g., dangerous stove,
2. IADL SUPPORT CODES:	If none apply, let the New York Collection and Cooling (e.g., too hot in summer, too cold
0. No support provided.	check NONE OF ABOVE. in winter, wood stove in a home with an asthmatic)
1. Supervision/cueing provided. 2. Set-up help only.	If temporarily f. Personal safety (e.g., fear of violence, safety
2. Set-up help only. 3. Physical assistance was provided. 4. Total dependence—the person was not involved at all when the activity was performed. 8. Activity did not occur.	in institution, base heavy traffic in street
4. Total dependence—the person was not involved at all when the activity was performed.  8. Activity did not occur.	assessment on home visit) g. Access to home (e.g., difficulty entering/leaving home)
8. Activity did not occur.	h. NONE OF ABOVE
1. DAILY a. Meal Preparation: Prepared breakfast INSTRU- and light meals.	3. TRADE Because of limited funds, during the last month, person made trade-offs in purchasing the following:
MENTAL b. Main Meal Preparation:	Check all that apply. a. home heat d. prescribed medications
ACTIVITIES Prepared or received main meal	b. adequate food e. home care.
level of times per week	c. necessary physician care f. NONE OF ABOVE
independence c. Telephone: Used telephone as necessary, based on e.g., able to contact people in an emergency.	SECTION R. MOOD
person's involvement d. Light Housework: Did light housework	1. INDICATORS Code for behavior in <b>last 30 days</b> irrespective of the assumed cause.
in the activity such as dishes, dusting (on daily basis), making own bed.	DEPRESSION, 0. Indicator not exhibited
days	ANXIETY, 1. Indicator of this type exhibited up to 5 days a week SAD MOOD 2. Indicator of this type exhibited daily or almost daily
2. OTHER a. Managing Finances: Managed own finances, INSTRU- including banking, handling checkbook,	(6, 7 days a week)
MENTAL paying bills.	VERBAL EXPRESSIONS OF h. Repetitive health complaints
ACTIVITIES OF DAILY  b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash	DISTRESS  a. Person made negative  —e.g., persistently seeks medical attention, obsessive
LIVING removal, cleaning bathroom, as needed.	statements-e.g., "Nothing a. concern with body functions
Code for level   c. Grocery Shopping: Did grocery shopping as of indepen- needed (excluding transportation).	dead; What's the use; complaints/concerns (non-
dence based d. Laundry:	Regrets having lived so health related)—e.g., long; Let me die." persistently seeks attention/
on person's involvement Indicate: In home out of home	b. Repetitive questions – e.g., reassurance regarding
in the activity Did laundry in home or at laundry facility in the last 14 (excluding transportation).	"Where do I go? What do I do?" clothing, relationship issues
days	c. Repetitive verbalizations-
3. TRANSPOR- a. Person drove self or used public transportation indepen-	e.g., calling out for help. ("God help me.")  j. Unpleasant mood in morning
TATION dently to get to medical, dental appointments, necessary engagements, or other activities.	d. Persistent anger with self or others-e.g., easily d. sleep pattern
that apply b. Person needed arrangement for transportation to medical, for level of dental appointments, necessary engagements, or other	annoyed; anger at place-
independence activities.	anger at care received I. Sad, pained, worried facial
based on person's C. Person needed transportation to medical, dental appointments, necessary engagements, or other activities.	e. Self-deprecation-e.g., "I am expressions—e.g., furrowed brows
in the activity d. Person needed escort to medical, dental appointments,	nothing; I am of no use to anyone."
in the last 30 necessary engagements, or other activities.	f. Expressions of what appear n. Repetitive physical movements—e.g., pacing,
4. PRIMARY Code for the primary mode of locomotion for (a)	e.g., fear of being hand-wringing, restlessness,
MODES OF indoors and (b) outdoors from the following list:	abandoned, left alone, fidgeting, picking being with others
4. PRIMARY MODES OF LOCOMO-TION 1. Cane Code for the primary mode of locomotion for (a) indoors and (b) outdoors from the following list: 5 oop 1 oop	g. Recurrent statements that  o. Withdrawal from activities
2. Walker/crutch a. b.	something terrible is about to happen—e.g., believes of interest—e.g., no interest o.
3. Scooter (e.g. Amigo)	he or she is about to die, being with family/friends
	p. Reduced social interaction
	2. MOOD One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up,"
	TENCE   console or reassure the person over the last 7 days.
	No mood indicators     I. Indicators present, easily altered

2. Indicators present, not easily altered

MOOD

Person's current mood status compared to person's status 180 days ago.

0. No change 1. Improved 2. Declined

Agency Name:	Applicant Name <u>:</u>	
Provider-Assessor #	Social Security #	
Assessment Date		
CONGREGATE HO	USING	
CH.1. In Section E, Physical Functioning/Structural Problems, are at least 2 ADI	Ls from the following: bed mobility, transfer,	
locomotion, dressing, eating, toilet use, or bathing coded with a 2, 3 or support?	4 in self-performance AND a 2 or 3 in Yes	No
CH.2. In Section P, Instrumental Activities of Daily Living, are at least 3 IADLs f 2.b routine housework, 2.c grocery shopping, 2.d laundry, coded with a support?		s No
CH.3. In Section E, Physical Functioning/Structural Problems, is at least 1 ADL locomotion, dressing, eating, toilet use, or bathing coded with a 2, 3, or AND in Section P, Instrumental Activities of Daily Living, are at least 2 IA preparation, 2.b routine housework, 2.c grocery shopping, 2.d laundry, 3 or 4 in support?	r 4 in self-performance and a 2 or 3 in support NDLs from the following: 1.b main meal coded with a 2 or 3 in self-performance and a	s No
If the answer to CH.1, CH.2, OR CH.3 is Yes, score this section with a "1". The consumer appears to be functionally eligible for Congregate Housing.		
ADULT DAY PRO	GRAM	
AD.1. In Section E, Physical Functioning/Structural Problems, were d., e., f bathing) all coded with a 5 (cueing) in self-performance AND support AD.2. In Section E, Physical Functioning/Structural Problems, were one or mobility, transfer, locomotion, eating, toilet use, bathing, or dressing	ort? OR more of the following 7 ADLs (bed	s No
self-performance AND a 2 or 3 in support?	Yes	No
If the answer to either AD.1. OR AD.2. is "YES," score this section with a "1."		
The consumer appears to be functionally eligible for the Adult Day Program	1.	
HOMEMAKER SE	TDV/CFS	
HOMEMAKER SE		
HM.1. In Section P, Instrumental Activities of Daily Living, are at least three preparation, 2b. routine housework, 2c. grocery shopping, or 2d. I or dependent) in self-performance AND a 3 or 4 in support? OR	laundry, coded with a 2 or 3 (needs assistance	s No
HM.2. In Section E. Physical Functioning/Structural Problems, are g. persons		
4 in self-performance AND a 2 or 3 in support AND are at least 2 of routine housework, 2c. grocery shopping, or 2d. laundry coded with support ?	n a 2 or 3 in self performance and a 3 or 4 in	s No
If the answer to either HM.1. OR HM.2. is "YES," score this section with a "1.	n	
Consumer appears to be functionally eligible for BEAS Homemaker Services		
MAINECARE DAY HEAL	TH SERVICES	
D.1. In Section E, Physical Functioning/Structural Problems, were d., e., f., bathing) all coded with a 5 (cueing) in self-performance AND suppo		s No
D.2. In Section E, Physical Functioning/Structural Problems, were two or metransfer, locomotion, eating, toilet use, bathing, or dressing) coded or 3 in support?	with a 2, 3 or 4 in self-performance AND a 2	s No
If the answer to either D.1. OR D.2. is "YES," score this section with a "1."  Consumer appears to be medically eligible for MaineCare Day Health Servic	ras.	
Consumer appears to be medically eligible for MaineCare Day Health Servic	es.	

Agency Na	ame:	Applicant Name <u>:</u>
Provider-A	ssessor #	Social Security #
Assessmer	nt Date	
	HOME BASED CARE	- LEVEL 1
H.1.A	In Section E, Physical Functioning/Structural Problems, were d., e., f., bathing) all coded with a 5 (cueing) in self-performance AND supports	= ' = ' '
H.1.B	In Section E, Physical Functioning/Structural Problems, how many ADI	s from the following 7 ADLs: bed
	mobility, transfer, locomotion, eating, toilet use, dressing, or bathing	were coded with a 2, 3 or 4 in
	self-performance AND a 2 or 3 in support?	
H.1.C	In Section A, items 1-11, Professional Nursing Services, how many bor nursing service at least one day a week)?	xes were coded with at least a T (needed
H.1.D	In Section P, Instrumental Activities of Daily Living, how many IADLs f	rom items 1h main meal preparation 2h
11.1.0	routine house work, 2c. grocery shopping, or 2d. laundry were coded	with a 2 or 2 (assistance/done
	with help or dependent/done by others) in self-performance AND a 3	3uii n.i.b +C +D
H.1.E	If the answer to H.1. (cueing) is "YES," score this section with a "1."	
H.1.F	If the person requires assistance with at least one ADL from the follo	,,
	locomotion, eating, toilet use, dressing, or bathing, AND the TOTAL s greater than 3, score this section with a "1."	core from H.I.B+C+D above is equal to or
	greater than 3, score this section with a 1.	
	HOME BASED CARE	- LEVEL 2
H.2	If person is medically eligible for Level II Private Duty Nursing (R.2D or score this section with a "1".	n page 5 of 7 under Eligibility Determination),
16 11 2 %		illa fan Hanna Barad Cana danid 2
IT H.2 IS	scored with a "1", the consumer appears to be functionally elig	ibie for Home Basea Care - Levei 2.
	HOME BASED CAR	E - LEVEL 3
H.3.A	In Section E, Physical Functioning/Structural Problems, are at least 2 A transfer, locomotion, eating, or toilet use coded with a 2, 3, or 4 in se Section P, Instrumental Activities of Daily Living, are at least 3 IADLs 1.b main meal preparation, 2.b routine housework, 2.c grocery shoppi	If-performance and a 2 or 3 in support <b>AND</b> in from the following:
	self-performance and a 3 or 4 in support?	
H.3	If the answer to H.3.A is Yes, score this section with a "1".	
	·	the factors Based Care Land 2
IF H.3 IS	scored with a "1", the consumer appears to be functionally elig	ivie for Home Basea Care - Level 3.
	HOME BASED CARE	: - LEVEL 4
H.4	If person is medically eligible for NF Level of Care (NF.7 on page 7 of section with a "1".	7 under Eligibility Determination), score this
If H.4 is	scored with a "1", the consumer appears to be functionally elig	ible for Home Based Care - Level 4.

	ELIGIBILITY DETERMINATION	ŀ	age 3 of 7
Agency Na	Name: Applicant Name:		
Provider-A	Assessor # Social Security #		
Assessifier			
	COGNITIVE CAPACITY FOR CONSUMER DIRECTED SERVICES		
Does con	nsumer have a Legal Guardian (Section A.17.a)?	Voc	No
	consumer does have a legal guardian, do not continue scoring for consumer-directed services. Consumer is sumer Directed Services.	Yes not eligible	- NO
If 'no', co	consumer does not have a legal guardian, then continue scoring for cognitive capacity.		
Ability to	to Self-direct Indicators:		
2. Making 3. Ability 4. Manag a. in	ion Making skills (Section C.3) = 0 or 1		
CC.1 If a	all the answers to the above questions are "Yes" then score this section with a "1".		
	appears to have cognitive capacity to self-direct their care.		
	MaineCare CONSUMER DIRECTED PCA SERVICES		
P.1	In Section E, Physical Functioning/Structural Problems, are at least 2 ADLs from the following: bed mobili transfer, locomotion, dressing, eating, toilet use, or bathing coded with a 2, 3, or 4 in self-performance as in support?		No
P.2	If the answer to P.1 is Yes, AND CC.1 (Cognitive Capacity) is scored with a "1", then score this section with	h a "1".	
If P.2 is	s scored with a "1", the consumer appears to be functionally eligible for MaineCare Consumer Directed s.	PCA	
	CONSUMER DIRECTED HOME BASED CARE		
CDH.1	In Section E, Physical Functioning/Structural Problems, how many ADLs from the following 7 ADLs: bed m transfer, locomotion, eating, toilet use, dressing, or bathing were coded with a 2, 3 or 4 in self-performan or 3 in support?		
CDH.2	In Section A, items 1-11, Professional Nursing Services, how many boxes were coded with at least a 1 (need nursing service at least one day a week)?	eded .	
CDH.3	In Section P, Instrumental Activities of Daily Living, how many IADLs from items 1b. main meal preparatio routine house work, 2c. grocery shopping, or 2d. laundry were coded with a 2 or 3 (assistance/done with dependent/done by others) in self-performance and a 3 or 4 in support?		
	Sum	CDH. 1+2 +3 = To	tal
CDH.4	If the person requires assistance with <b>at least one ADL</b> from CDH.1, <b>AND</b> the TOTAL score above is equal greater than 3, score this section with a "1."	l to or	
CDH.5	If CDH.4 is "1" AND CC.1 (Cognitive Capacity) is scored with a "1", then score this section with a "1".		
If CDH.5 Services.	5 is scored with a "1", the consumer appears to be functionally eligible for Consumer Directed Home E s.	Based Care	
	MaineCare PHYSICALLY DISABLED HCB		
PDW. 1	Is person medically eligible for NF Level of Care (NF.7 on page 7 of 7 under Eligibility Determination)?	Yes _	No
PDW.2	If the answer to PDW.1 is Yes, AND CC.1 (Cognitive Capacity) is scored with a '1', then score this section v	with a "1".	
If PDW.2	2 is scored with a "1", the consumer appears to be functionally eligible for MaineCare Physically Disal	oled HCBS.	

		•	age . c.
Agency Name:	_ Applicant Name:		
Provider-Assessor #	Social Security #		
Assessment Date:			
ADULT FAMILY CARE	HOMES - LEVEL 1		
Cueing/Limited Assistance			
AF.1. a. In Section E, (Physical Functioning/Structural Problems), are the ADLs fro and bathing) coded with a 5 (cueing required 7 days a week) in self-peri			
b. In Section E, Physical Functioning/Structural Problems, were 2 or more	***	Yes	No
transfer, locomotion, eating, toilet use, bathing, or dressing coded with	a 2, 3 or 4 in self-performance and	Yes	No
coded with a 2 or 3 in support?	The consumer appears to be	. 00	
If the answer to either of these questions is "YES," score this section with a "1." I eligible for Level 1 of Adult Family Care Homes.	The Consumer appears to be		
	HOMES LEVELS		
ADULT FAMILY CARE Extensive Assistance	HOMES - LEVEL 2		
AF.2. a. In Section E, (Physical Functioning/Structural Problems), is at least one A	ADL from items a, b, c, e, and f (bed mobility,		
transfer, locomotion, eating, or toilet use), coded with a 3 or 4 (extensi	ve assistance or total dependence)	Yes	No
in self-performance and a 2 or 3 in support? AND b. In Section E, (Physical Functioning/Structural Problems), are at least two	(2) additional ADI s from itoms		
a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use)		Yes	No
(limited assistance, extensive assistance, or total dependence) in self-pe		165 —	_ INO
If the answer to both of these questions is "YES," then score this section with a "1	." The consumer appears to		
be eligible for Level 2 of Adult Family Care Homes.			ш
Cognitive Impairment		V	NI.
AF.3. a. Is Section C1a (short term memory) coded with a 1? b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is	s C2e. None of the Ahove, checked (Person is	Yes	_ No
able to recall no more than 2 items)?	5 CZE, Notice of the Above, checked (Ferson is	Yes	No
c. Is Section C3 coded with a 2 or 3?		Yes	No
d. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs	· · · · · · · · · · · · · · · · · · ·		
transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limit dependence) in self-performance and coded with a 2 or 3 in support?	ted assistance, extensive assistance, or total	Yes	No
If the answer to all of the above questions is "YES," then score this section with a	"1." The consumer appears to be eligible for		
Level 2 of Adult Family Care Homes.			
Behavioral Symptoms	itame a h and a (wandaring warhall)		
AF.4. a. In Section D, Problem Behavior, are one or more of the behaviors from abusive, physically abusive) coded with a 2 or 3?	items a, b and c (wandering, verbally	Yes	No
OR are at least 3 of the behaviors from items a, b, c and d coded with a	a 1 (behavior of this type occurred on 1-3		
days only)?		Yes	No
b. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs	· · · · · · · · · · · · · · · · · · ·		
transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limit dependence) in self-performance and coded with a 2 or 3 in support?	ted assistance, extensive assistance, or total	Yes —	No
If the answer to both of these questions is "YES," then score this section with a "1	." The consumer appears to be eligible for		
Level 2 of Adult Family Care Homes.			
ADULT FAMILY CARE	HOMES - LEVEL 3		
Cognitive Impairment			
AF.5. a. Is Section C1a (short term memory) coded with a 1?		Yes	No
b. In Section C2 (memory recall) are only 1 or 2 boxes checked in C2a-C2c	l or is C2e,		
None of the Above, checked (Person is able to recall no more than 2 ite	!ms)?	Yes	
<ul> <li>c. Is Section C3 coded with a 2 or 3?</li> <li>d. In Section E, (Physical Functioning/Structural Problems), are at least 4 A</li> </ul>	Dis from items a big a and f (bad mobility	Yes —	— No ——
transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limit	• • • • • • • • • • • • • • • • • • • •	Yes	No
dependence) in self-performance and coded with a 2 or 3 in support?		100	_110
If the answer to all of the above questions is "YES," then score this section with a	า "1." The consumer appears to be eligible for		
Level 3 of Adult Family Care Homes.			
<b>Behavioral Symptoms</b> AF.6. a. In Section D, Problem Behavior, are one or more of the behaviors from	items a h and c (wandering verbally		
abusive, physically abusive) coded with a 2 or 3?	nems a, b and c (wandering, verbally	Yes	No
<b>OR</b> are at least 3 of the behaviors from items a, b, c and d coded with a	a 1 (behavior of this type occurred		
on 1-3 days only)?		Yes	No
b. In Section E, (Physical Functioning/Structural Problems), are at least 4 Al		V.	
(bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2 extensive assistance, or total dependence) in self-performance and code		Yes	No
If the answer to both of these questions is "YES," then score this section with a "1			
Level 3 of Adult Family Care Homes			

Agency Name: Appl	licant Name:	
	al Security #	
	at Security #	
Assessment Date		
PDN/PCS LEVEL	1	
P.1.A. In Clinical Datail Section E. Physical Eunstioning (Structural Problem	as were d a fand 4 (drossing	
R.1.A In Clinical Detail, Section E, Physical Functioning/Structural Problem eating, toilet use, and bathing) all coded with a '5' (cueing) in Self-Performan		
R.1.B In Clinical Detail, Section E, Physical Functioning/Structural Problem	ns, were 2 of the following 7 ADLs	-
(bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) co <b>Performance</b> AND a 2 or 3 in <b>Support</b> ?	Yes No	_
R.1.C If the answer to either of these questions is 'yes,' then score this section	on with a '1'. Person appears to be	
eligible for PDN-Level 1.		
PDN/PCS NURSING SO	CORE	
Private Duty Nursing	5? Yes No	
RN.A. a. In Section A, Nursing Services, were any items 1-8 coded with a 1, 2, 3, or 5 b. In Section A, item 9 (Ventilator/Respirator), did you code this response with		
c. In Section A, item 10 (uncontrolled seizures) did you code this response with		
d. In Section A, was item 12, therapy, coded with a 1 (therapy needed once a	V N-	
e. In Section A, was item 13, Assessment/Management, coded with a 1 (asses	, Na - Na	_
If the answer to any of these questions is "YES," then score this section with a "1."		
Professional Nursing Services		
RN.B. In Section B.1 - B.2, Special Treatments and Therapies, were any boxes coded	with a 1, 2, or 3? Yes No	_
If the answer is "YES," then score this section with a "1."		
Impaired Cognition	Yes No	
RN.C. a. Is Section C1a (short term memory) coded with a 1?		-
b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C None of the Above, checked (Person is able to recall no more than 2 items		-
c. Is Section C3 coded with a 2 or 3?	Yes No	-
d. Is Section C5 coded with a 1 (i.e. is professional nursing assessment, obs		
required once a month to manage all the above cognitive patterns)?	Yes No	
If all the answers to the above questions are "YES," then score this section with a "1.	n	
Behavior Problems	Voc. No.	
RN.D. a. In Section D, Problem Behavior, are one or more of the behaviors a-d code		-
b. Is Section D3 coded with a 1 (i.e. is professional nursing assessment, obserguired once a month to manage the above behavior problems)?	ervations and management  Yes No	
If the answer to both of these questions is "YES," then score this section with a "1."		
.,		
RN.E. Compute the total PDN nursing score from questions RN.A., RN.B., RN.C. and	d RN.D.	_
If the Total nursing score is 1 or more, proceed. Otherwise, the person appears NOT	to be medically eligible for PDN Level II or Level III.	
PDN/PCS LEVEL	2	
R.2.A In Clinical Detail, Section E, Physical Functioning/Structural Problem	ns, were d, e, f, and 4 (dressing,	
eating, toilet use, and bathing) all coded with a '5' (cueing) in Self-Performan R.2.B In Clinical Detail, Section E, Physical Functioning/Structural Problems		-
(bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) co		
Performance AND a 2 or 3 in Support?		-
R.2.C ADL Needs Score: If the answer to either R.2.A or R.2.B is 'yes' then sco R.2.D PDN-Level 2 Eligibility Determination (RN.E + R.2.C)		
a. In RN.E, is the PDN Nursing Score '1' or more?	Yes No Yes No	
<ul><li>b. In R.2.C, is the ADL Needs Score '1'?</li><li>If the answer to both of these questions is YES, score '1' in the box. The person</li></ul>		-
<b>Level 2.</b> Otherwise, the person appears <b>NOT</b> to be eligible for <b>PDN-Level 2</b> .	on appears to be engible for <b>1 Di</b>	
PDN/PCS LEVEL 3	3	
R.3.A In Clinical Detail, Section E, Physical Functioning/Structural Problem		
Shaded ADLs (bed mobility, transfer, locomotion, eating, toilet use) coded with		-
AND a 2 or 3 in <b>Support</b> ? <b>R.3.B ADL Needs Score</b> : If the answer to <b>R.3.A</b> is 'yes' then score this section.	with a '1'.	
R.3.C PDN-Level 3 Eligibility Determination (RN.E + R.3.B)	Yes No	
a. In RN.E, is the PDN Nursing Score '1' or more?	Yes No	_
b. In <b>R.3.B</b> , is the ADL Needs Score '1'?  If the answer to both of these questions is YES, score '1' in the box. The person		
<b>Level 3.</b> Otherwise, the person appears <b>NOT</b> to be eligible for <b>PDN-Level 3</b> .	J	

Agency Name: App	Applicant Name:					
Provider-Assessor # Soci	al Security #					
Assessment Date:						
PDN/PCS Level	V					
EXP.1. In Section A, was item 9 (Ventilator/Respirator) coded with a 4 (nur week)?	Yes No					
If the answer is YES, then person appears to be medically eligible for Extende	ed PDN. Score 1 in the box.					
If the answer is NO. then proceed to EXP.2.	<u> </u>					
EXP.2a. In Section A, was one of the items from 1 (Injections/IV Feedings),	2 (Feedina Tube), 3 (Suctioning/					
Trach Care), 4 (Treatment/Dressings), 8 (Comatose), or 10 (Uncont	· 3 // · 3/					
(service needed at least once every 8 hours, 7 days a week)?	d with a 42 Yes No					
2b. In Section A, were 2 additional items from 1, 2, 3, 4, 8, or 10 codes of the answer to BOTH 2a. and 2b. is YES, then person appears to be medical	u with a +:					
Score 1 in the box.	ny englole for Extended FDIN.					
If NO, then person appears to NOT be medically eligible for Extended PDN.						
PDN Level VI MEDICATION SERVICES FOR PERSONS WITH	H SEVERE AND DISABLING MENTAL ILLNESS					
R.10. a. Is there a physician certification in the person's record verifying t coverage for services under Section 17?	he person's eligibility or Yes No					
b. Has a physician certified that use of outpatient services is contrai	ndicated for this person? Yes No					
If the answer to both of these questions is "YES", then score this section with	n a "1".					
R.11. a. In Section G, Medication, is G1a, Preparation/Administration, code	d with a 6? Yes No					
b. In Section G, Medication, is G1b, Compliance, coded with a 4?	Yes No					
If the answer to either of these questions is "YES", then score this section with						
If the answer to both R.10. and R.11. is scored with a "1" then this person a Services under Private Duty Nursing. Otherwise, this person appears NC Services.						
PDN Level VII VENIPUNCTURE	ONLY SERVICES					
R.12. a. Is there a physician order in the person's record for only venipunc	ture services on a regular basis? Yes No					
b. Has a physician certified that use of outpatient services is contrain	dicated for this person? Yes No					
c. In Section B, Special Treatments and Therapies, is B.1.e, Venipunctu	ure, coded with a 1, 2, or 3? Yes No					
If the answers to R.12 a., b., and c. are "YES", then score this section with a for Venipuncture Services under Private Duty Nursing.	"1". Person appears to be eligible					

Agency Name:	Applicant Name:		
Provider-Assessor #	Social Security #		
Assessment Date			
NF LEVEL O	F CARE		
NF.1. a. In Section A, Nursing Services, items 1-8, did you code any of the res (i.e., services needed 7 days/week)?	ponses with a 4	Yes No_	
b. In Section A, item 9 (Ventilator/Respirator) did you code this respons days/week)?	Yes No		
c. In Section A, item 10 (Uncontrolled Seizure), did you code this respor once/week)?	Yes No		
d. In Section A, item 11 (Therapies), was the total number of days of the	erapy 5 or more days/week?	Yes No	
e. In Section E. (Physical Functioning/Structural Problems), were 3 or mo (extensive assistance) or 4 (dependent) in self performance?	ore shaded ADLs coded with a 3	Yes No	
If the answer to any of these questions is "YES," then the person appears medi	ically eligible for NF level care. Otherwise continue.	103 110	
	, -		
PROFESSIONAL NURSING SERVICES:			
NF.2. a. In Section A, Nursing Services, items 1-8, how many were coded with	a 2 or 3 (service needed 3-6 days/week)? Fnte	er number.	
b. In Section A, item 11 (Therapies), was the total number of days of the	• • • • • • • • • • • • • • • • • • • •		
c. In Section B, items 1a-1e and 1g-1j (excluding 1f, monthly injections)	**	o 1-Yes	
d. In Section B, items 2a-2d, did you code any of the responses with a 2		o 1-Yes	
Compute the nursing services score from 2a-2d and enter it here.			
		Total	
NF.3. Impaired Cognition			
a. Is Section C1a (short term memory) coded with a 1?		Yes No	
b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d o	r is C2e (None of the Above) checked		
(Person is able to recall no more than 2 items)? c. Is Section C3 coded with a 2 or 3?		Yes No_ Yes No_	
d. [Is Section C4A coded with a 1] <b>OR</b> [in Section E, is at least one shad and a 2 or 3 in support AND C4B (from page 2A Supplemental Screer		Yes No	
If all the answers to the above questions are "yes," then score this section with	n a "1."		
NF.4. Behavior Problems			
a. In Section D, are one or more of the behaviors from items a-d (wand	ering, verbally abusive, physically abusive,		
socially inappropriate behavior) coded with a 2 or 3?		YesNo _	
b. [Is Section D2A coded with a 1] <b>OR</b> [in Section E, is at least one shad	ded ADL coded with a 2, 3 or 4 in self-performance		
and a 2 or 3 in support AND D2B (from page 2A Supplemental Screer	ning Tool) is 14 or more]?	YesNo_	
If the answer to both questions is yes, then score this section with a "1."			
NF.5. Compute the total nursing score from questions 2, 3 and 4. If the total		erson	
appears not to be medically eligible for NF level of care. Please proce	ed to next page. Total !	Nursing	
NF.6. In Section E (Physical Functioning/Structural Problems), how many "sh	aded" ADLs were coded with a 2, 3 or 4 in self-		
performance AND required a one or more physical assist in support (s	support coded as 2 or 3)? Total AD	L Needs	
NF.7. Total Nursing and ADL Needs Score (NF.5 + NF.6)			
If the Total Nursing and ADL Needs Score is 3 or more, the person appears to	o he medically eliaible for NF level of care		
Otherwise, person appears not to be medically eligible. Proceed to next page.			
,, ,,,,,,			

### **COMMUNITY OPTIONS CARE PLAN SUMMARY**

Age	ncy Name:						Applican	it Name <u>:</u>					
Prov	ider-Asses:	sor #					Social Se	ecurity #		-			
Δςς	essment Da	ate						L					
ASS	essillelli Da												
					0=0=10								
							PORT SERVI	CES					
1.	EXTENT OF HELP		ntal and persona			ceived	3. CAREGI STAT						
		friends, and		days, indicate extent of help from family, ighbors.				,,   4.					
	(HOURS OF CARE	a. Sum of tir	ne across five we	eekdays		HOUKS	that ap	ו (עומי			_	continue in	caring
	ROUNDED)	<b>b.</b> Sum of tir	ne across two we	across two weekend days  a.					activities (e.g., decline in the				e health of the
2.		NAME OF PE	RSON 1 and PE	N 1 and PERSON 2					caregiver makes it difficult to continue)  c. Primary caregiver is unable to identify othe				
	TWO KEY INFORMAL												
	HELPERS	A. (Last/Fam	ily Name)	(First)					helpers or unable to provide additional care should the need arise (e.g., cannot do more, other caregivers not available, or no funds to				
	(Information	,											
	on two family members,	B. (Last/Fam	ily Name)	(First)					hire he				C.
	friends, or neighbors	a. Lives with	client 0 - NC	(A) (B) O 1 - YES Pers 1 Pers 2				a.	<b>d.</b> Primary caregiver is not received from family an				n support a other
	most relied or	1 I		such helper						n of clie		ueus (e.,	d.
	ADLs or IADL (or could be	.s <b>b.</b> Relations	nip to client						e. Primary caregiver expresses feelings of				of e.
	relied on, if no	o   0 - Child d		2 - Other Relati 3 - Friend/Neig					distress		ssion has	ause of cari	
	with these activities)	1 Spous	-	5 Tricila/Neig	IIDOI				client	or depre	331011 Dec	ause of carr	f.
$\Box$		1			4. Person A						5. Person	ı B	
			A. Current # wkday		C. Will	D. Will	E. Extent of					D. Will	
			hours	wkend hours	increase # wkday	increase # wkend	# knowledge 0=full	wkday hours		kend ours	increase wkday		
En	ter Number	of Hours			hours	hours	1=partial				hours	hours	
a.	Advice or em	notional suppo	rt				2=none						2=none
b.	ADL care												
c.	ADL care												
d.	Supervision	only											
		-	Refer to	the coding sh	neet on pre	vious page	when filling	out this	care pl	an sumi	mary.		
	AEDICARE /	ODD DARTY DA	YORS:										
6. 1	MEDICARE/	3RD PARTY PA	YORS:			4 DUDA	TION						
	1	2		3	4	4. DURA	TION 4b		5	6		7	8
F	1 unding	2 Service	Reason Coo	3 de/Need Met	St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1	2	Reason Coo	3 de/Need Met ons for service)	St	a	4b	lι			of Units		
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	lι	Jnit	Avg # c	of Units	Rate per	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	C	Init ode	Avg # c	of Units Ionth	Rate per Unit	TOTAL Cost
F	1 unding	2 Service	Reason Coo		St	a art	4b End	C	Init ode	Avg # c	of Units	Rate per Unit	TOTAL Cost
F	1 Junding Source	2 Service Category	Reason Coo	ons for service)	St	art art ate	4b End Date	C	Init ode	Avg # c	of Units Ionth	Rate per Unit	TOTAL Cost
F	1 Junding Source	2 Service Category	Reason Coo (List all reason)	ons for service)	St Da	a art ate ate 4. DURA	4b End Date	C	MEDIC/	Avg # c per M	PARTY T	Rate per Unit	TOTAL Cost per Month
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 funding Source	2 Service Category	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	Avg # c per M	PARTY T	Rate per Unit	TOTAL Cost per Month
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date	C	MEDIC	AVg # c per M  ARE/3RD  Avg # c	PARTY T	Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost
7.	1 (unding Source	2 Service Category  SOURCES/SER	Reason Coo (List all reason 	ons for service)	St Da	4. DURA	4b End Date		MEDIC/ 5 Juit ode	AVG # C per M	PARTY T	OTAL  7 Rate per Unit	TOTAL Cost per Month  8 TOTAL Cost

- funding source which will pay for the recommended service.
- 2. SERVICE CATEGORY: Enter the appropriate code to indicate the service category recommended to meet
- 3. REASON CODES: Enter the reason code for recommended service/need being met.
- proposed service.
- 5. UNIT CODE: Enter the unit of time which is used in calculating the cost of this service.
- 6. NUMBER OF UNITS: Enter the number of units needed per month to meet the person's needs.
- on the maximum allowable MaineCare rate for that specific unit of service in this program as found in the appropriate MaineCare manual.
- 8. TOTAL COST: Calculate the total cost per month for this service.

OUTCOME Page 1 of 1

			U	UICC	/IVIL				Page 1 01	
Agency Name:					Applicant Na	ame <u>:</u>				
Provider-Assessor #					Social Secur	ity#				
Assessment Date:					MaineCare#					
SECTIO	ON T. ASSESSME	NT TYPE/VER	SION			SECTION	V. AWAIT	NG PLACEMENT		
1. TYPE	nitial (original) <b>2.</b> Ro	oaccoccmont		=	1. a. FOR: <b>0.</b>	NA 1. NF	2. MaineCare	HCB - Elderly, AD 3.	PDN	
	ilitiai (Origiliai) 2. Ki	eassessillellt		<b></b>	b. AT:	<b>0.</b> NA	3. Home			
1	5	onversion	5. Reinstated	_		1. NF	4. Out-of-			
	Revision <b>4.</b> Pe	ending appeal	6. Update	┙!		2. Hospita	l (specify)			
COMMUNITY   2 C	ssessment Reques			_	c. Valid elig	ibility: from		to	_ 0 - NA	
I PROGRAM I	heck all that apply.	,	ii scoring pages			SECTION	N W NE/HC	SP/HHA DATES		
A ED	F	∃   <del>X</del>								
. ASMNT EQUESTEC	ASMI				1. Acute care	denial date <u>:</u>				
_ 8	- 5	2. PF			2. First Non-SI	NF Date:				
	rm Care Advisory ny Care Program		copay to NF MaineCa Community MaineCar		3. Last day pri	ivate pay <u>:</u>			_	
3. BEAS Ho	ome Maker		ry to MaineCare Updat		4. Late notific	ation date	0 - No	1 - Yes		
	are Day Health er Directed PCA		ledicare to Private Pay	NF						
6. Home Ba			uing Stay Review rdinary Circumstances	to NF	5. Bed hold ex		0 - <b>N</b> o	1 - Yes	L	
7. Phys. Di 8. Elderly F		22.Katie E			6. Home Healt			E FACILITY	0 - NA	
	Disability HCB		IV - NF PDN egate Housing		1 MEH I			FFACILITY		
10.PDN - Le		25.TBI			a. Will be en     b. Is curren	-	0 - No 0 - No	1 - Yes 1 - Yes		
	mily Care Home  Extended PDN		Care Home Health ledication - Level VI			•		1 - 1es	 □ 0 - NA	
13.NF Asses			enipuncture Only - Lev	vel VII						
	ledicare/MaineCare e to MaineCare	29.Cons.	Directed HBC		d. Eligibility	start date: _			0 - NA	
4. CONSUMER 1. C		2.41:			e. Reassess	date:			0 - NA	
CHOICE	Community Options Residential Care	<b>4.</b> No choice	IIY 5. NF		f. End date	::			0 - NA	
(Choose one.)	ram referrals given to co		sorv	_	(30-day I	MaineCare only	/)			
PLAN	-		0 - No 1 - Yes		g. Admissio				☐ 0 - NA	
	ory medical eligibility d from:		•			SECTION	ON Y. LATE	SUBMISSION		
			O-	-NA	la. Reason:	der not chose	<b>1b.</b> To:	. BMS □c. BEAS	☐ 0 - NA	
1. Based on this asse	TION U. NF MEDI					ncial pending		. HCCA d. Other		
eligible for NF leve	el of care.	er appears to be n - 0		$\neg    $	c. Cons	umer request				
Complete regardle	ess of consumer choic	ce								
			SECTION 7.	COMMU	INITY BENEF	ITS				
FUNDING SOURCE (	(from Care Plan)		PROVIDI			LIGIBILITY S	TART DATE	REASSESS DATE	WAIT LIST	
			RESIDENT	TIAL CAR	RE REFERRA	L				
		BENE	ITS DENIED					NOTICE D	ATES	
FUNDING SOURCE		ACTION	REASON	10-DAY	DISCHARGE D	ATE DISCH	ARGE TO	Date of denial:		
								10-day Date:		
								60-day Notice:		
						Appeal Reinstate 0 - No 1 - Yes				
					IDE			Date:		
				SIGNATU	JKE					
Assessment Date	Assessment Date Assessment Version							Signature Date		
			FOR OFFIC	E USE O	NLY BEAS/B	BFI				
☐ APRC	BEA	AS request date			to					
_		•	n date							
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